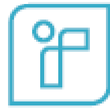

Russell Medical
SLEEP DISORDER CENTER

SLEEP DISORDERS QUESTIONNAIRE

PLEASE PRINT AND COMPLETE ALL INFORMATION

(Complete this questionnaire and bring it with you to your appointment)

Please assume that "daytime" means your normal waking hours and "nighttime" means your normal sleeping hours. Also, assume that "weekday" refers to the days you work and "weekend" refers to those you do not work.

NAME: ☐ SSN: ☐ DATE: ☐

REFERRING PHYSICIAN: ☐ PHONE: ☐

HEIGHT: ☐ WEIGHT: ☐ LBS. COLLAR SIZE: ☐ PANTS/DRESS SIZE: ☐

How did you hear about The Sleep Center? ☐ Doctor ☐ Friend ☐ Newspaper ☐ Internet ☐ Radio

☐ Other ☐

Do you live alone? ☐ Yes ☐ No Do you have a regular bed partner? ☐ Yes ☐ No

CHIEF COMPLAINT

What is your main sleep problem? (Reason for Referral)

In general, which categories below would your sleep problem best fit? (Please check all that apply)

- ☐ SNORING
- ☐ EXCESSIVE SLEEPINESS OR FATIGUE
- ☐ DIFFICULTY GETTING TO SLEEP OR STAYING ASLEEP
- ☐ ABNORMAL OR UNUSUAL BEHAVIOR DURING SLEEP, LEG MOVEMENTS/JERKING
- ☐ INTERRUPTIONS IN BREATHING
- ☐ PROBLEMS MAINTAINING SLEEP (WAKE UP TOO OFTEN)
- ☐ POOR QUALITY OF SLEEP
- ☐ OTHER ☐

What are your bed partner's main complaints about your sleep? (Please check all that apply)

- ☐ SNORING
- ☐ EXCESSIVE SLEEPINESS OR FATIGUE
- ☐ DIFFICULTY GETTING TO SLEEP OR STAYING ASLEEP
- ☐ ABNORMAL OR UNUSUAL BEHAVIOR DURING SLEEP, LEG MOVEMENTS/JERKING
- ☐ INTERRUPTIONS IN BREATHING
- ☐ PROBLEMS MAINTAINING SLEEP (WAKE UP TOO OFTEN)
- ☐ POOR QUALITY OF SLEEP
- ☐ OTHER ☐

On the scale below, how would you rate the severity of your complaints? (Choose one)

☐ Mildly Upsetting ☐ Moderately Severe ☐ Very Severe

How strongly do you want help with this problem? (Choose one only)

☐ Mildly ☐ Moderately ☐ Very

Name:____ **Birthdate:** _______________

SLEEP HISTORY

Is the quality of your sleep? ☐ Good ☐ Fair ☐ Poor

How long has this problem been present? ☐ Months / ☐ Years

How long has this problem bothered you? ☐ Months / ☐ Years

Have you had previous occurrences of this problem? ☐ Yes / ☐ No

How many times per week does the problem bother you? ________

Has your sleeping pattern changed? ☐ Yes / ☐ No

Do you have daytime sleepiness or nighttime sleeplessness? ☐ Yes / ☐ No

Do you fall asleep easily or awaken early? ☐ Yes / ☐ No

PREVIOUS EVALUATION/TREATMENT

Do you have any other problems with your sleep? (Problem Duration)

a. ________________________ ☐ Months / ☐ Years

b. ________________________ ☐ Months / ☐ Years

Have you had a sleep problem diagnosed in the past? ☐ Yes / ☐ No

If yes, what was the problem? ________________________

Where was the diagnosis made/by whom? ________________________

What medication(s) / treatment was (were) tried or recommended? (Check those tried)

☐ Adderall	☐ Ambien	☐ Ativan	☐ Chloral Hydrate
☐ Celexa	☐ CPAP	☐ Cylert	☐ Dalmane
☐ Desoxyn	☐ Desyrel	☐ Dexedrine	☐ Doral
☐ Effexor	☐ Halcion	☐ Klonopin	☐ melatonin
☐ mirapex	☐ neurontin	☐ Paxil	☐ Phenobarbital
☐ Provigil	☐ Prozac	☐ Quinine	☐ Remeron
☐ Restoril	☐ Ritalin	☐ Sinemet	☐ Sonata
☐ Wellbutrin	☐ Xanax	☐ Xyrem	☐ Other ________

Surgeries?

☐ Nasal Septal Repair ☐ Somnoplasty ☐ Uvulopalatopharyngoplasty ☐ Other

Suggested Behavioral Changes?

☐ Strict Bed Schedule ☐ Warm Bath ☐ Other ________________________

What treatment helped? ________________________

Name:_______________________________________ **Birthdate:** _______________

SLEEP SCHEDULE

	Weekdays (Workdays)	Weekends (Off Work)
Bedtime am/pm		
Rise Time am/pm		
Time to sleep onset (minutes)		
Duration of Sleep (hours)		
Variation in Bedtime during 1 week	Hours/Minutes	
Variation in rise time during 1 week	Hours/Minutes	
Frequency of awakening		

What awakens you?

- ☐ Urination
- ☐ Shortness of Breath
- ☐ Heartburn/Reflux
- ☐ Body Jerking
- ☐ Animal
- ☐ Unknown/not sure
- ☐ Heat
- ☐ Noise
- ☐ Cold
- ☐ Light
- ☐ Child
- ☐ Other

NAPPING

Number per workday

Number per weekend day

Time of day you nap

Average length of nap? hr./min

Do you dream during your naps? ☐ Yes / ☐ No

Are you refreshed by your naps? ☐ Yes / ☐ No

Take naps on arrival home from work? ☐ Yes / ☐ No

Are short naps refreshing (10-15 min) ☐ Yes / ☐ No

If you had the opportunity, could you nap during the day? ☐ Yes / ☐ No

SLEEP SYMPTOMS

EXCESSIVE SLEEPINESS

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Awaken feeling rested and refreshed	☐	☐	☐	☐	☐
Fall asleep before noon if not active	☐	☐	☐	☐	☐
Fall asleep during active tasks before noon	☐	☐	☐	☐	☐
Experience sleepiness before lunch	☐	☐	☐	☐	☐
Fall asleep in the afternoon if not active	☐	☐	☐	☐	☐
Fall asleep during active tasks in the afternoon	☐	☐	☐	☐	☐
Have trouble at school or work due to sleepiness	☐	☐	☐	☐	☐
Fall asleep easily	☐	☐	☐	☐	☐
Can sleep 12 hours or more at a time	☐	☐	☐	☐	☐
Feel excessively sleepy in the daytime	☐	☐	☐	☐	☐
Feel your sleepiness is a result of poor quality sleep	☐	☐	☐	☐	☐
Have fallen asleep driving a car	☐	☐	☐	☐	☐

How many near miss accidents because of drowsiness or sleepiness have you had in the past 12 months?

Has your sexual relationship been affected because you are tired or sleepy? ☐ Yes / ☐ No

Name:_______________________________________ Birthdate: _______________

EPWORTH SLEEPINESS SCALE

These questions are about your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation:

0 Would *never* doze
1 *Slight* chance of dozing
2 *Moderate* chance of dozing
3 *High* chance of dozing.

ACTIVITY	CHANCE OF DOZING
Sitting and reading	
Watching TV	
Sitting inactive in a public place (meeting, theater, etc.)	
As a passenger in a car for 1 hour without a break	
Lying down in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	
TOTAL	

SNORING

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Sleep separately from your bed partner?	☐	☐	☐	☐	☐
Your bed partner leaves the bedroom because of your sleep problem?	☐	☐	☐	☐	☐
Has your bed partner told you that you stop breathing in your sleep?	☐	☐	☐	☐	☐
Snore?	☐	☐	☐	☐	☐

Please circle "loudness" rating below, for your snoring:

Patient's rating: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (very loud & disturbing)

Bed partner's rating: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (very loud & disturbing)

Does position affect your snoring? ☐ Yes / ☐ No

If yes, in which position do you snore most loudly?

☐ Back ☐ Right side ☐ Left side ☐ Stomach ☐ Other: ______

Name:_______________________________________ **Birthdate:** ______________

NOCTURNAL SYMPTOMS

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Wake yourself coughing	☐	☐	☐	☐	☐
Wake up choking or short of breath	☐	☐	☐	☐	☐
Wake up with stomach acid taste in your mouth or belching	☐	☐	☐	☐	☐
Wake up with dry mouth/sore throat/headache	☐	☐	☐	☐	☐
Wake up confused or inconsolable	☐	☐	☐	☐	☐
Have awakened from snorting in your sleep	☐	☐	☐	☐	☐
Awaken at night with chest pain or heaviness	☐	☐	☐	☐	☐
Awaken panicked or anxious	☐	☐	☐	☐	☐
Have difficulty lying flat in bed because of fullness in the throat	☐	☐	☐	☐	☐
Wake up with your heart beating irregularly	☐	☐	☐	☐	☐

NUTRITION

Do you currently use artificial sweeteners? ☐ Yes / ☐ No, if Yes, Which ones ______

Last meal of the day eaten at ______ ☐ a.m./ ☐ p.m.

Have you experienced any weight gain over the past months or years? (check which)

☐ Yes / ☐ No, if yes, how much weight have you gained? ______ pounds

Weight 1 year ago ______ lbs. Weight 5 years ago ______ lbs.

Do you feel your sleepiness is associated with weight gain? ☐ Yes / ☐ No

Have you tried to diet? ☐ Yes / ☐ No

Have you been successful at keeping the weight off? ☐ Yes / ☐ No

SLEEP HYGIENE

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Read in bed	☐	☐	☐	☐	☐
Watch TV in bed	☐	☐	☐	☐	☐
Write in bed	☐	☐	☐	☐	☐
Eat in bed	☐	☐	☐	☐	☐
Have arguments in bed	☐	☐	☐	☐	☐
Worry in bed	☐	☐	☐	☐	☐
Keep a regular sleep/wake schedule	☐	☐	☐	☐	☐

Do you change/swing shifts at work? ☐ Yes / ☐ No, If Yes, what hours ______

Do you now do shift or night work? ☐ Yes / ☐ No, if yes, what hours do you work? ______

Have you done shift work or night work in the past? ☐ Yes / ☐ No, if yes, what hours do you work? ______

If you could set your own schedule, at what time would you go to bed? ______ ☐ a.m./ ☐ p.m.

At what time would you get up? ______ ☐ a.m./ ☐ p.m.

How many days a week do you exercise? ______

Do you notice problems with sleep when you travel, especially in the eastward direction, i.e. jet lag? ☐ Yes / ☐ No

Name:______________________________________ **Birthdate:** ______________

INSOMNIA

Please rate how often you:	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Have nighttime sleeplessness?	☐	☐	☐	☐	☐
Have trouble getting to sleep at night?	☐	☐	☐	☐	☐
Have prolonged periods when you are awake and can't get back to sleep?	☐	☐	☐	☐	☐
Wake up one to two hours early in the morning?	☐	☐	☐	☐	☐
Have thoughts racing through your mind while you are trying to fall asleep?	☐	☐	☐	☐	☐
Watch the clock while trying to fall asleep?	☐	☐	☐	☐	☐
Are unable to fall asleep in 15 minutes or less?	☐	☐	☐	☐	☐
Wake up several times during the night and cannot get back to sleep?	☐	☐	☐	☐	☐

If yes, for how long are you awake over the night when added together? ________ Minutes Total

Does awakening too early and not being able to get back to sleep bother you? ☐ Yes / ☐ No

PARASOMNIAS

Please rate how often you:	**Never**	**Rarely**	**Sometimes**	**Frequently**	**Constantly**
Have dreamless sleep	☐	☐	☐	☐	☐
Remember your dreams	☐	☐	☐	☐	☐
Have nightmares	☐	☐	☐	☐	☐
Have night terrors	☐	☐	☐	☐	☐
Walk in your sleep	☐	☐	☐	☐	☐
Talk in your sleep	☐	☐	☐	☐	☐
Wake up feeling stiff in the mornings	☐	☐	☐	☐	☐
Wake up with sore or achy muscles	☐	☐	☐	☐	☐
Wake up with pain in neck, spine, or joints	☐	☐	☐	☐	☐
Have morning jaw pain	☐	☐	☐	☐	☐
Grind teeth during sleep	☐	☐	☐	☐	☐
Clench teeth during the day	☐	☐	☐	☐	☐
Have you noticed you get up and eat during the night in your sleep	☐	☐	☐	☐	☐
Have leg cramps at bedtime	☐	☐	☐	☐	☐
Have experienced uncontrolled urination in your sleep (either as a child or an adult)	☐	☐	☐	☐	☐
Sweat excessively at night	☐	☐	☐	☐	☐
Feel the uncontrollable urge to sleep during the day especially when very mad, happy or sad	☐	☐	☐	☐	☐

Name:______________________________________ **Birthdate:** ______________

Have you ever felt sudden muscle weakness when you laughed, got angry, got surprised or while having sex? ☐ Yes / ☐ No, if yes, describe: ______

Have you ever been unable to move your body just as you were falling asleep or waking up? ☐ Yes / ☐ No, if yes, describe: ______

Have you ever had any visual hallucinations or exceptionally vivid dreams just as you were falling asleep or waking up? ☐ Yes / ☐ No, if yes, describe: ______

Episodes of flailing your arms/kicking your legs/screaming in your sleep? ☐ Yes / ☐ No

Do you recall a dream or dream fragment preceding these episodes?
______ Daily ______ Weekly ______ 1-3 times per month ☐ Never

Are you confused during these episodes? ☐ Yes / ☐ No

Do you remember these episodes in the morning? ☐ Yes / ☐ No, if yes, describe: ______

MOVEMENT

Please rate how often you:	Never	Rarely	Sometimes	Frequently	Constantly
Bed covers extremely messy when you wake up?	☐	☐	☐	☐	☐
Awaken yourself by kicking your legs during the night?	☐	☐	☐	☐	☐
Bed partner complains of your leg kicking during the night?	☐	☐	☐	☐	☐
Experience a restless or uncomfortable sensation in your legs?	☐	☐	☐	☐	☐
Experience a creeping/crawling sensation; pain or discomfort in your legs at rest?	☐	☐	☐	☐	☐
Have been told you act out your dreams or nightmares by swinging your arms or legs or yelling?	☐	☐	☐	☐	☐
Have been told that your legs move every 20 seconds or so throughout the night?	☐	☐	☐	☐	☐

MEDICAL HISTORY

Do you currently have or have you ever been diagnosed with:

Head Trauma ☐ Yes / ☐ No

Muscular tension ☐ Yes / ☐ No

Meningitis ☐ Yes / ☐ No

Eating Disorder ☐ Yes / ☐ No

Are bothered by pain during the day ☐ Yes / ☐ No

Experience any type of pain during the day ☐ Yes / ☐ No

Decrease in sexual function or interest ☐ Yes / ☐ No

FAMILY HISTORY

Do other members of your family snore? ☐ Yes / ☐ No; if yes, explain: ______

Name:_____________________________________ **Birthdate:** ______________

Do other members of your immediate family have daytime sleepiness? ☐ Yes / ☐ No**;** if yes, explain:

Do other members of your immediate family have any other sleep problems? ☐ Yes / ☐ No**;** if yes, explain:

PSYCHOLOGICAL HISTORY

Do you feel depressed? ☐ Never ☐ Occasionally ☐ Frequent ☐ Always

Are you sad; are you unable to enjoy your daily activities? ☐ Yes / ☐ No

Do you experience a lot of stress in your day to day life or work? ☐ Yes / ☐ No

Do you experience irritability, memory problems, or lack of concentration? ☐ Yes / ☐ No

Has your mood recently changed? ☐ Yes / ☐ No

Do you have anxiety (worries about family or financial problems)? ☐ Yes / ☐ No

Do you have experienced claustrophobia or get "panicky" in crowded places? ☐ Yes / ☐ No

Do you have trouble concentrating? ☐ Yes / ☐ No

Do you have poor memory? ☐ Yes / ☐ No

Have you experienced a personality change in the past year? ☐ Yes / ☐ No; If yes, describe:

Have you ever seen a psychiatrist or any type of counselor? ☐ Yes / ☐ No

Within the last year, has depression, anxiety or stress interfered with your sleep? ☐ Yes / ☐ No; If yes, describe:

Do you have any other comments regarding your sleep?